1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11960

Reg. Dist. No. 11944

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 202 Center St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 202 Center St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: MORRIS Middle: SLEMMONS Last: ADAMS

4. DATE OF DEATH Month: OCTOBER Day: 11 th Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 15,1897
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR Months: 9 Days: 26 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Md. State Roads Commission
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wicomico County Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Adams
14. MOTHER'S MAIDEN NAME: Hettie Ennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs.Anna C.Adams(Wife) Address: 202 Center St. Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
420.0 DUE TO (b)	Arteriosclerotic heart disease	years
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchogenic Carcinoma — Rt lobectomy 4-21-57

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 12-7, 1954, to 10-11, 1959, that I last saw the deceased alive on 9-28, 1959, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl L Royer M.D.
ADDRESS (Street, city or town, state): 407 Camden Ave. Salisbury,Maryland
DATE SIGNED: October 12 /1959
PHYSICIAN'S NAME (Type): Dr.Earl L.Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct.14,1959
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

11945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: WICOMICO MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WICOMICO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRUITLAND — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRUITLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): GREEN ST	d. STREET ADDRESS: GREEN ST. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: JOHN Middle: WALTER Last: BANKS

4. DATE OF DEATH Month: OCTOBER Day: 13 th Year: 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 10,1901

9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman-Mechantic

10b. KIND OF BUSINESS OR INDUSTRY: Self-employeed

11. BIRTHPLACE (State or foreign country): Fruitland,Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John F.Banks

14. MOTHER'S MAIDEN NAME: Alverta Brumbley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk

16. SOCIAL SECURITY NO.: 212-12-3864

17. INFORMANT Address: Mrs.Alma V.Banks(Wife)Green St. Fruitland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shot gun wound of upper abdomen — INTERVAL BETWEEN ONSET AND DEATH: Sudden

976 X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted

20c. TIME OF INJURY Hour: 12:05 p. m. Month, Day, Year: 10 13 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Fruitland Wicomico Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: October 15 1959

EXAMINER'S NAME (Type): Dr.Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.16,1959

22c. NAME OF CEMETERY OR CREMATORY: Zion Cemetery

22d. LOCATION (City, town, or county) (State): Near Fruitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11946

Items 3,5,14. See: Birth Cert. et

Reg. Dist. No.

M

C

I

1. PLACE OF DEATH a. COUNTY: 11961 Wicomico MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Md

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)

a. STATE: Maryland b. COUNTY: Wic.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 - Salisbury

d. STREET ADDRESS: 12 Patrick ave

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First / Middle / Last: ~~Baby~~ Andre Carlile Barkley

4. DATE OF DEATH Month Day Year: 10-8-59 19

5. SEX: Male

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27,1959

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 1 Days 11. IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Salisbury Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: McKinley Barkley

14. MOTHER'S MAIDEN NAME: Alberta ~~Barkley~~ L. Veney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): |

16. SOCIAL SECURITY NO.: |

17. INFORMANT Address: ~~12 Patrick~~ Alberta Barkley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Asphyxia	Sudden
921.0 DUE TO (b)	Aspiration of vomitus	Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Found dead in bed.

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 1:50 P.M. 10-8-59

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home.

20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-13-59

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-14-59

22c. NAME OF CEMETERY OR CREMATORY: Glen Acres Cem

22d. LOCATION (City, town, or county) (State): Salisbury Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Brooker M West

24a. REC'D BY REGISTRAR DATE: OCT 15 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

VS. A15ME(S) 5M 9/55

2 22 2

208236 GXVG

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 18 Film 250 10-22-59 ams

11962

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 618 South Division St

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 618 S. Division St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: DONALD Middle: ALBRO Last: BEACH
4. DATE OF DEATH Month: OCTOBER Day: 17th Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 6,1907
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR Months: 4 Days: 11 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Auto Parts-
10b. KIND OF BUSINESS OR INDUSTRY: Employee
11. BIRTHPLACE (State or foreign country): ~~XXXXXX~~,Holland,Mich.
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Harry A.Beach
14. MOTHER'S MAIDEN NAME: Mabel Siggins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs.Maude E.Beach(Wife)R.D.# Schumaker Road Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion
INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Dr.Earl L.Royer
DATE SIGNED: October 19 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct.20,1959
22c. NAME OF CEMETERY OR CREMATORY: Pollitt's Family Cemetery-R.D.#Schumaker Road
22d. LOCATION (City, town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPA NY ADDRESS: SALISBURY,MARYLAND
24a. REC'D BY REGISTRAR DATE: OCT 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

I

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11948

Reg. Dist. No.

1. PLACE OF DEATH 11963
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury (Rural)
d. STREET ADDRESS: RD #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Dalton Middle: Vance Last: Brittingham Jr.

4. DATE OF DEATH Month Day Year: 10-22-59 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 10, 1959
9. AGE (in years last birthday): — yrs. IF UNDER 1 YEAR: Months 6 Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dalton Vance Brittingham, Sr.
14. MOTHER'S MAIDEN NAME: Beatrice Willey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Dalton V. Brittingham, Sr. Address: RD #3 Salisbury, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
925.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ **or CONTRIBUTING** ☐ **CAUSE OF DEATH.**
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child found smothered with plastic bag.
20c. TIME OF INJURY Hour a.m./p.m. Month, Day, Year: 11:43 A.M. 10-22-59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home.
20f. (City or town) Salisbury (County) Wic (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-22-59
EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 24, 1959
22c. NAME OF CEMETERY OR CREMATORY: Hebron Cemetery
22d. LOCATION (City, town, or county) (State): Georgetown (County) Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: William ... Jr. ADDRESS: Georgetown, Del.
24a. REC'D BY REGISTRAR DATE OCT 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

M C I 082 v 0 22 2

VS. A1SME(S)
5M 9/55

208224 4XUS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11949

1. PLACE OF DEATH 11964
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - STOCKTON
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: WILLIAM Middle: THOMAS Last: Brown

4. DATE OF DEATH Month: October Day: 9 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 7, 1888

9. AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: GENERAL STORE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM THOMAS BROWN

14. MOTHER'S MAIDEN NAME: SARAH WHITE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 224-14-8447

INFORMANT Address: W. LEONARD BROWN, POCOMOKE CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Gastric Dilatation
DUE TO (c) Carcinoma of Pancreas c̄ Metastases to Liver

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 4, 1959, to Oct. 9, 1959, that I last saw the deceased alive on Oct. 9, 1959, and that death occurred at 9 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill, Jr. M.D.
ADDRESS (Street, city or town, state): Pine Bluff Road, Salisbury, Md
DATE SIGNED: 10/9/59
PHYSICIAN'S NAME (Type): THOMAS C. HILL JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/59
22c. NAME OF CEMETERY ~~OR CREMATORY~~: FRANKLIN CEMETERY
22d LOCATION (City, town, or county) (State): WORCESTER COUNTY, MD.

23 FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: Pocomoke Md.

24a. REC'D BY REGISTRAR DATE OCT 13 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Kuhn

VS A15 (4)
15M 9/58

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

FOR STATE HEALTH DEPT.

TO DEPUTY ME[redacted] EXAMINER: This certificate should be executed within 24 hours after death. If any delay is ne[redacted]ssary, please execute the ce[redacted]te, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11950

11965 Item 7 File 6250 10-16-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fruitland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Moses Middle: Last: Bunting

4. DATE OF DEATH Month Day Year: 10-10-59 19

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 11th 1895
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Accomack County, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Fannie Bunting

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Victor Bunting Address: Fruitland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured cervical spine
INTERVAL BETWEEN ONSET AND DEATH: Sudden
822X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Passenger in car that ran off road and turned over.

20c. TIME OF INJURY Hour: 5 P.M. Month, Day, Year: 10-10-59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Back road.
20f. (City or town): Eden (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-11-59
EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 18, 1959
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Shiloh Baptist
22d. LOCATION (City, town, or county): Painter, R.F.D. (Boston) (State): Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] Thomas Funeral Home ADDRESS: Accomac, Va.
24a. REC'D BY REGISTRAR DATE: OCT 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

11951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 704 E.Church St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury

d. STREET ADDRESS: 1 704 E.Church St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: LYDIA Middle: MAE Last: BURBAGE

4. DATE OF DEATH Month: October Day: 6 th Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept.18,1904

9. AGE (In years last birthday): 55 yrs — IF UNDER 1 YEAR: Months 8 Days 18 — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Parsensburg,Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William H. Timmons

14. MOTHER'S MAIDEN NAME: Jane Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT / Address: Mr. Edward W.Burbage(Husband) 704 E. Church St Salisbury,Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	coronary occlusion	5 min
420.1 DUE TO (b)	coronary atheromatosis	2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): hypertension, essential —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 9-18 1957, to 10-8 1959, that I last saw the deceased alive on 10-2 1957, and that death occurred at 2:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.V.Sohler M.D.

ADDRESS (Street, city or town, state): Delmar, Maryland

DATE SIGNED: Oct. 8 /1959

PHYSICIAN'S NAME (Type): Dr. L.V.Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-

22b. DATE THEREOF: Oct.9,1959

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11967 11952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Del. St. Ext. Morris Camp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Catherine Middle: Last: Carter

4. DATE OF DEATH Month Day Year: 10-31-59 19

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 2, 1920
9. AGE (In years last birthday): 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: James Wilson
14. MOTHER'S MAIDEN NAME: Mary Roberson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joshua Wilson Address 493 Rardin ave. pahokee Florida

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shot gun wound of abdomen — INTERVAL BETWEEN ONSET AND DEATH: Sudden
181X
DUE TO (b)
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot by John Wilkes at 111 Lake St. Salisbury, Md.
20c. TIME OF INJURY Hour: 7:40 P.M. Month, Day, Year: 10-31-59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): The Spot-Bar.
20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
DATE SIGNED: ~~11-3~~ 11-3-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/7/1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive
22d. LOCATION (City, town, or county): Fruitland (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart ADDRESS: Salisbury Md.
24a. REC'D BY REGISTRAR DATE: NOV 10 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY M[redacted]L EXAMINER: This certificate should be executed within 24 hours after death. If any delay [redacted]sary, please execute the cert[redacted] writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral dir[redacted] Page 4 should be forwarded to [redacted] Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2

2

VS. A15ME(5)
5M 9/55

TO HOSPITAL OR [redacted]NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of [redacted]eath. Page 4 may be retained [redacted]e hospital or attending physician.
TO FUNERAL DIREC[redacted]: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

11953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland; b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury; c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	d. STREET ADDRESS: 301 Anne Street; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First / Middle / Last: Jesse Thomas Cartwright	4. DATE OF DEATH Month / Day / Year: October 9, 1959

5. SEX	6. COLOR OR RACE	7.	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	White	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	July 20, 1919	40 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Self Employed	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Walter Cartwright	Amy Frances Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
Yes — World War #2		Mrs. Frances Martin	313 Front St, Oceania, Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/8, 1959 to 10/9, 1959 that I last saw the deceased alive on 10/9, 1959, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry J Mattax M.D. — ADDRESS (Street, city or town, state): 711 Camden Ave — DATE SIGNED

1

PHYSICIAN'S NAME (Type): Harry Mattax, MD, Salisbury, MD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10-12-59	Charity Church Cem.	Princess Anne Co. Va.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Holloman-Brown-Cmaye	Norfolk, Virginia	DATE OCT 14 '59	Arthur S. Kraus

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11969

CERTIFICATE OF DEATH

Reg. Dist. No. 11954

1. PLACE OF DEATH a. COUNTY: WICOMICO MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: WORCESTER
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY — c. LENGTH OF STAY IN 1b: 12 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL	d. STREET ADDRESS: 104 LAUREL STREET. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: JOHN Middle: N. Last: CLARKE

4. DATE OF DEATH: Month: OCTOBER Day: 16 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/21/1891

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CLERK

10b. KIND OF BUSINESS OR INDUSTRY: DRUGSTORE

11. BIRTHPLACE (State or foreign country): POCOMOKE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARION T. CLARKE

14. MOTHER'S MAIDEN NAME: MINNIE MILLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): YES — WAR #1

16. SOCIAL SECURITY NO.:

INFORMANT: MRS. RUTH Y. CLARKE — Address: (POCOMOKE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Cerebral Atherosclerosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Stenosis · bronchiectasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from Sept. 1958, to Oct. 16 1959 that I last saw the deceased alive on Oct. 16 1959, and that death occurred at 9 35 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: Oct. 16, 1959

PHYSICIAN'S NAME (Type): DAVID J. GILMORE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/19/59

22c. NAME OF CEMETERY OR CREMATORY: BETHANY METHODIST

22d. LOCATION (City, town, or county): POCOMOKE (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H Watson — ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR DATE: OCT 21 '59

24b. REGISTRAR'S SIGNATURE: William S. Thomas

TO HOSPITAL OR [illegible]TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours o[illegible]eath. Page 4 may be retained [illegible]he hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 ... 10-16-59 et

11970

CERTIFICATE OF DEATH

11955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL	d. STREET ADDRESS: 683 Fitzwater St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF [redacted] (Type or print) — First: Clarence — Middle: — Last: CUSTIS

4. DATE OF DEATH — Month: October — Day: 5, — Year: 1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
MALE	NEGRO.	Never married	unknown	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
labor		Maryland	U.S.A.

13. FATHER'S NAME: George Custis

14. MOTHER'S MAIDEN NAME: Imia white.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): 3al

16. SOCIAL SECURITY NO.:

INFORMANT — Address: Willie Jones, Jeffreys St. Salisbury Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism of Coronary Arteries

464 ^

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Acute Thrombophlebitis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 19, 1959, to Oct 5, 1959, that I last saw the deceased alive on 10/5/59, 19____, and that death occurred at 4 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Carrie Hearn M.D. — ADDRESS (Street, city or town, state): 226 N. Division St. Salisbury Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): CARRIE HEARN.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	10/8/1959	green acres	Salisbury	Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart — ADDRESS: Salisbury Md

24a. REC'D BY REGISTRAR DATE OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

VS A15 (4) 15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11971

CERTIFICATE OF DEATH

Reg. Dist. No. 11956

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: N. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) — First: PAUL — Middle: MITCHELL — Last: DAVIS

4. DATE OF DEATH — Month: OCTOBER — Day: 15 — Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 24, 1908

9. AGE (In years last birthday): 50 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POLICEMAN

10b. KIND OF BUSINESS OR INDUSTRY: TOWN

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH. H. DAVIS

14. MOTHER'S MAIDEN NAME: ALICE MITCHELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 218-20-6698

INFORMANT: MRS. P. M. DAVIS — Address: BERLIN MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 8 days

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I **certify** that I attended the deceased from 10-7, 1959 to 10-15, 1959 that I last saw the deceased alive on 10-15, 1959, and that death occurred at 11 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Elliott M.D. — ADDRESS (Street, city or town, state): Berlin, Md. — DATE SIGNED: 10-15-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10 / 19 / 59

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county): BERLIN — (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna R. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: OCT 20 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 X

M

11972

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11957
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Delaware b. COUNTY: Sussex

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital
d. STREET ADDRESS: Williams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Paul Middle: K. Last: DeBoer
4. DATE OF DEATH Month: October Day: 22 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 14, 1897
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Dry Goods
11. BIRTHPLACE (State or foreign country): Montpelier Vt.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph A DeBoer
14. MOTHER'S MAIDEN NAME: Augusta Featherly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): World War 1 & 2
16. SOCIAL SECURITY NO: 009-09-5434
INFORMANT: Helen DeBoer — Address: Selbyville, Del.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fibrosarcoma of Lung, Metastatic

1 X

DUE TO (b) from Right forearm — 18 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 11, 1959, to Oct. 22, 1959, that I last saw the deceased alive on October 21, 1959, and that death occurred at 2^05 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill, Jr. M.D.
ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury Md
DATE SIGNED: 10/22/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 10/26/59
22c. NAME OF CEMETERY OR CREMATORY: Green Mountain
22d. LOCATION (City, town or county) (State): Montpelier Vermont

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Watson & Whaley, Selbyville Del
24a. REC'D BY REGISTRAR DATE: OCT 26 59
24b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12012 **CERTIFICATE OF DEATH** 11958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards / c. LENGTH OF STAY IN 1b: Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: ALFRED Middle: C. Last: DENNIS

4. DATE OF DEATH Month: Oct. Day: 19 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: May 22, 1920
9. AGE (In years last birthday): 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Willards
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ray Dennis
14. MOTHER'S MAIDEN NAME: Lillie Dennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-12-5499
17. INFORMANT: Mrs. Hilda Dennis Address: Willards, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary carcinoma c metastasis bone — INTERVAL BETWEEN ONSET AND DEATH: 8 mo
DUE TO (b) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) — (County) — (State)

21. I certify that I attended the deceased from January 1959, to 10-19 1959, that I last saw the deceased alive on 10-19 1959, and that death occurred at 2:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Lewis M.D. ADDRESS (Street, city or town, state): Willards, Maryland DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/21/59
22c. NAME OF CEMETERY OR CREMATORY: Dennis
22d. LOCATION (City, town, or county) (State): Willards, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Selbyville, Del.
24a. REC'D BY REGISTRAR DATE OCT 21 '59
24b. REGISTRAR'S SIGNATURE: [illegible] S. Kraus

TO HOSPITAL O[redacted]ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be ret[redacted]he hospital or attending physician.
TO FUNERAL [redacted]OR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11973 **CERTIFICATE OF DEATH** 11959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

d. STREET ADDRESS: 314 Cherry Way

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: ESTELLE Middle: MAE Last: Dennis

4. DATE OF DEATH Month: October Day: 15 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 9,1889

9. AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Phila, Pa.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Wesley Marley

14. MOTHER'S MAIDEN NAME: Alice Emma Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT / Address: Mr.Virgil W.Dennis(Husband)314 Cherry Way (P.O.B.#24) Salisbury,Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible] — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10-3, 1959 to 10-15, 1959, that I last saw the deceased alive on 10-15, 1959, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED: 10-15-59

PHYSICIAN'S NAME (Type): Dr.Wilber R.Ellis Jr. Medical Center- Salisbury,Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.19,1959

22c. NAME OF CEMETERY OR CREMATORY: Washington National Cem.Co.

22d. LOCATION (City, town, or county) (State): Washington 20,D.C. Suitland, ~~Maryland~~ Rd.

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 20 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/58

1 X 11974 11960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE: Maryland b. COUNTY: Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: VINCENT Middle: W. Last: DENNIS

4. DATE OF DEATH Month: October Day: 8 Year: 1959

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: TIRE CO.

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN DENNIS

14. MOTHER'S MAIDEN NAME: NETTIE BRITTINGHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WORLD WAR 2

16. SOCIAL SECURITY NO: 219-12-8106

INFORMANT Address: MRS NETTIE DENNIS BERLIN MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): acute congestive heart failure — 1 hour

DUE TO (b): previous myocardial infarction — 6 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Coronary artery disease — 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1953 to Oct. 8, 1959, that I last saw the deceased alive on Oct. 8, 1959, and that death occurred at 11:47 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Grubb MD M.D — ADDRESS (Street, city or town, state): BERLIN, MD. — DATE SIGNED: 10/8/59

PHY[redacted]AN'S NAME (Type): ROBERT A. GRUBB, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 10/11/59

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d LOCATION (City, town, or county): BERLIN (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Anna A. Burbage Berlin Md

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VH A1S (4)
15M 9/58

1 X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12013 **CERTIFICATE OF DEATH** 11962

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY* Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHARPTOWN
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD.
b. COUNTY Wico.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Sharptown
d. STREET ADDRESS MARDELA R.F.D. 1
e. IS RESIDENCE ON A FARM? YES [x] NO [ ]

3. NAME OF DECEASED (Type or print) First RHUEL Middle E. Last GOSLEE
4. DATE OF DEATH Month OCTOBER Day 31 Year 1959

5. SEX MALE
6. COLOR OR RACE Col.
7. MARRIED [x] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH JAN. 16, 1899
9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLANd.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CharLES E. GOSLEE
14. MOTHER'S MAIDEN NAME ANNIE G. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. 217-10-8602
17. INFORMANT MARTHA GOSLEE Address R.F.D. 1 MARDELA MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral Hemmorhage
260X
DUE TO (b) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Arteriosclerosis [illegible]
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1, 1959, to Oct 31, 1959, that I last saw the deceased alive on Oct 31 1959, 19____, and that death occurred at 4 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED

PHYSICIAN'S NAME (Type) Charles M [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF NOV. 5, 1959
22c. NAME OF CEMETERY OR CREMATORY ZION-CEMETERY
22d. LOCATION (City, town, or county) SharPtown (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart ADDRESS Salisbury Md.
24a. REC'D BY REGISTRAR DATE NOV 10 '59
24b. REGISTRAR'S SIGNATURE Arthur [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death [illegible] may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4.

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11975

Reg. Dist. No. 11963

- 1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
- b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
- c. LENGTH OF STAY IN 1b:
- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springhill Sanitarium
- 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
- d. STREET ADDRESS: Route 50
- e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
- 3. NAME OF DECEASED (Type or print) First: Edwin Middle: Derrickson Last: Harrington
- 4. DATE OF DEATH Month: October Day: 8, Year: 1959
- 5. SEX: male
- 6. COLOR OR RACE: white
- 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
- 8. DATE OF BIRTH: Jan. 5, 1894
- 9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min.
- 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate
- 10b. KIND OF BUSINESS OR INDUSTRY:
- 11. BIRTHPLACE (State or foreign country): Maryland
- 12. CITIZEN OF WHAT COUNTRY? U. S.
- 13. FATHER'S NAME: Frank Harrington
- 14. MOTHER'S MAIDEN NAME: Isadore Pritchett
- 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): War 1
- 16. SOCIAL SECURITY NO.:
- 17. INFORMANT / Address: Pauline Humphreys: Salisbury, Md.

MEDICAL CERTIFICATION

- 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
  - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
  - 420.0
  - DUE TO (b)
  - DUE TO (c)
  - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
  - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
- 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
- 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
- 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
- 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
- 20d. INJURY OCCURRED While at work ☐ Not while at work ☐
- 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
- 20f. (City or town) (County) (State)
- 21. I certify that I attended the deceased from 7/10, 1958 to 10/8/59, 19__, that I last saw the deceased alive on 10/7, 1959, and that death occurred at 8 P M, from the causes and on the date stated above.
  - ACTUAL SIGNATURE: H. R. Ozamse M.D.
  - ADDRESS (Street, city or town, state): Salisbury, Md.
  - DATE SIGNED:
  - PHYSICIAN'S NAME (Type):
- 22a. BURIAL, CREMATION, REMOVAL (Specify): burial
- 22b. DATE THEREOF: 10/11/59
- 22c. NAME OF CEMETERY OR CREMATORY: John Wesley
- 22d. LOCATION (City, town, or county): Mt. Vernon (State): Maryland
- 23. FUNERAL DIRECTOR'S SIGNATURE: James Hinman
- ADDRESS: Princess Anne, Md.
- 24a. REC'D BY REGISTRAR DATE: OCT 16 '59
- 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS 15 (4)
15M 9/58

1 X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11976

11964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 308 N.Division St.(Crew-Mor Apts)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury

d. STREET ADDRESS: 1 308 N.Div.St.(Crew-Mor Apts)

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: SARAH Middle: ALICE Last: HORNER

4. DATE OF DEATH Month: OCTOBER Day: 10th Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Aug. 7,1892

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Shirt Factory-Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sussex Co. Delaware

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Isaac Levin Foskey

14. MOTHER'S MAIDEN NAME: Rosa Gertrude Truitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.Lois H.Pusey(Daughter) Address: 308 N.Div.St. (Crew-Mor Apts) Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mon

155.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of Gall Bladder — 1 yr?

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 8.11, 1959 to 10.10, 1959 that I last saw the deceased alive on 10.9.59, 19 , and that death occurred at 7:40P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H A Briele M.D. ADDRESS (Street, city or town, state) DATE SIGNED: October 12/59

HENRY A. BRIELE

PHYSICIAN'S NAME (Type): Dr. ~~William H. Fisher~~ Jr. Medical Center - Salisbury,Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.13,1959

22c. NAME OF CEMETERY OR CREMATORY: Hebron Cemetery

22d. LOCATION (City, town or county) (State): Hebron, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 1 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

[illegible]

1

MARYLAND STATE DE[redacted] HEALTH—BALTIMORE, 18

CE[redacted]ATE OF DEATH

11965

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury; c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen Hospital	d. STREET ADDRESS R.D.# 3(Delmar Rd.); e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: PAUL	Middle: R.	Last: HUETHER
4. DATE OF DEATH	Month: OCTOBER	Day: 7th	Year: 1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Male	White	Married	June 22, 1913	46 yrs	4	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Asst. Manager-Swift & Co.(D.& P.)		Baltimore, Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Conrad Huether	Martha Rasmussen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT / Address
No		Mrs.Frances M.Huether(Wife) R.D.# 3 Delmar Rd. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis, bilateral, severe

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Multiple emboli to kidneys, brain, lungs — 2-3 days

DUE TO (c) and rt. common iliac artery, sup. mesenteric artery

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-1, 1959 to 10-7, 1959 that I last saw the deceased alive on 10-7, 1959, and that death occurred at 1:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE William H. Fisher Jr. M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED Oct. 8 /1959

PHYSICIAN'S NAME (Type) Dr. William H.Fisher Jr. Medical Center Salisbury,Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct.10,1959	Parsons Cemetery	Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY MARYLAND	DATE OCT 13 '59	Arthur B. Kraus

TO HOSPITAL OR [redacted]ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a[redacted]eath. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11966
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jack — Middle: — Last: Jester
4. DATE OF DEATH: Month Day Year: 10-27-59 — 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 4 1942
9. AGE (In years last birthday): 17 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT KENNETH JESTER
14. MOTHER'S MAIDEN NAME: LIDA MAE BRASURE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 216-38-8802
17. INFORMANT: LIDA MAE ROUNDS — Address: RD#2 Salisbury MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sub-dural hemorrhage-left.
INTERVAL BETWEEN ONSET AND DEATH: 3 days
816X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in car involved in collision on Rt. # 313
20c. TIME OF INJURY: Hour 9:30 a.m. — Month, Day, Year: 10-24-59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RT # 313
20f. (City or town): Mardela — (County): Wicomico — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
DATE SIGNED: 10-27-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 29, 59
22c. NAME OF CEMETERY OR CREMATORY: ST. JOHNSTOWN Cemetery
22d. LOCATION (City, town, or county): GREENWOOD — (State): Dela.

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARY LAND
24a. REC'D BY REGISTRAR: DATE NOV 2 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11979

CERTIFICATE OF DEATH

Reg. Dist. No. 11967

1 PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hosp

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Salisbury
d. STREET ADDRESS: R.D.# Pemberton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARL Middle LEE Last Jones

4. DATE OF DEATH: Month October Day 22 Year 1959

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6th 1887

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Asst.Dist.Supt.

10b. KIND OF BUSINESS OR INDUSTRY: (Prudential Life Ins Co.)

11 BIRTHPLACE (State or foreign country): Mt.Vernon,Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George W.Jones

14. MOTHER'S MAIDEN NAME: Virginia Bloodsworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs.Agnes Jones(Wife) **Address** Pemberton Drive Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 days

420.1

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

0

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from ______ 1950 to 10/22 1959, that I last saw the deceased alive on 10/22 1959, and that death occurred at 5:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: F. R. Gramse M.D.

ADDRESS (Street, city or town, state): Salisbury, Md

DATE SIGNED: Oct.22,1959

PHYSICIAN'S NAME (Type): Dr.Fred R.Gramse — S.Division St. Salisbury, Maryland

1

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: Oct.24,1959

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d LOCATION (City, town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY **ADDRESS** SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 23 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL O TTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a death. Page 4 may be retained the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

M

I

1 M

11968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Weti uin — c. LENGTH OF STAY IN 1b: Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Wetipquin
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
	John		Jones		10-11-59 19

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
M	C	Widowed	10-11-81	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
W term n	Oyster Tonger	Maryl nd	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Jones	Sarah A, --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	--	------	Orenzie Jones, Weti uin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — hours

420.1

DUE TO (b) ASCVD — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from; Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L Royer M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 10-13-59

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/14/59	Odd Fellows Cem.	Weti uin, d.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
C. F. Jessup, Liv lve, rylnd	OCT 16 59	Clifford S. Musk

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is ory, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

TO HOSPITAL OR
may be

NG PHYSICIAN: The law
aspital or attending pl
After this certificate h
ed for use as the

d within 24 hours after

tely filled in by the

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11875 **CERTIFICATE OF DEATH** 11879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
d. STREET ADDRESS 108 N. 8th St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Milton Middle E. Last Jones
4. DATE OF DEATH Month October Day 21 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct. 13-1888
9. AGE (In years last birthday) 70 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Physician
10b. KIND OF BUSINESS OR INDUSTRY Urologist
11. BIRTHPLACE (State or foreign country) Snidertia, Md
12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME Thompson Jones
14. MOTHER'S MAIDEN NAME Ruth Smack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO None
17. INFORMANT Mrs Ruth A. Jones Address Ocean City, Md 108 N. 8th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Degenerative Heart Disease
4 d 2.2
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-20-, 1958, to 10-21-, 1958, that I last saw the deceased alive on ______, 19___, and that death occurred at 4:45 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE William R. Ellis Jr. M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 10-21-58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried
22b. DATE THEREOF Oct 23/58
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery
22d. LOCATION (City, town, or county) Snidertia (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS Snow Hill, Md
24a. REC'D BY REGISTRAR DATE OCT 23 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

I

...retained ... FUNERAL DIREC...
page 3 should be detached ...
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...15 (4)
...0/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See birth certificate on file

11980

CERTIFICATE OF DEATH

11969

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mardela Rt. #1
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First William Middle Howard Last Jones

4. DATE OF DEATH Month October Day 13, Year 1959

5 SEX Male

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH October 12, 1959

9. AGE (In years last birthday) - yrs

IF UNDER 1 YEAR Months - Days -

IF UNDER 24 HRS. Hours 14 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Wicomico Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Howard L. Jones

14. MOTHER'S MAIDEN NAME Madeline Esther Winder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

INFORMANT Mother Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
DUE TO (b) Prematurity (Birth wt. 1340 gms)
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH approx 14 1/2 hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/12 1959 to 10/13 1959, that I last saw the deceased alive on 10/13 1959 and that death occurred at 5:35 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Alfred C. Kolls M.D.

ADDRESS (Street, city or town, state) Medical Center Salisbury Maryland

DATE SIGNED 10/13/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)

22b DATE THEREOF October 13, 1959

22c. NAME OF CEMETERY OR CREMATORY John Wesley

22d. LOCATION (City, town, or county) Mardela (State) Maryland

23 FUNERAL DIRECTOR'S SIGNATURE Father Howard L. Jones ADDRESS

24a. REC'D BY REGISTRAR DATE OCT 16 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2. 0 4 4 1 X J V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11981

CERTIFICATE OF DEATH

Reg. Dist. No. 11970

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Pr. Sani.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury
d. STREET ADDRESS 1 Schumaker Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MAGGIE Middle GRAYCE Last KNUDSON

4. DATE OF DEATH Month 10 Day 14 Year 1959

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb.23,1885

9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hans Ferbitz

14. MOTHER'S MAIDEN NAME Christine Sorenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 483-09-4101

17. INFORMANT Address Mr. Benjamin F. Knudson, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease
INTERVAL BETWEEN ONSET AND DEATH 2 yrs
44 X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959, to 10-14, 1959, that I last saw the deceased alive on 10-13, 1959, and that death occurred at 11.45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Philip A. Insley M.D. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 10/16/59

PHYSICIAN'S NAME (Type) Dr. Philip A. Insley East Main St., Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10-17-59

22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State) Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE OCT 19 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) 1SM 9/55

Norman T. Bacon

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11982

11971
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Powellville
c. LENGTH OF STAY IN 1b: 11 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Nichols Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Willards
d. STREET ADDRESS: R. F. D.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First: William Middle: E. Last: Lecates

4. DATE OF DEATH Month: 10 Day: 14 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 6/4/1872

9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Del.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alexander Lecates

14. MOTHER'S MAIDEN NAME: Isabell Ricketts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO

17. INFORMANT Address: Oliver Lecates - Frankford - Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular accident
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Hypertensive C.V. Disease
DUE TO (c) [illegible]
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1958 to 10/14, 1959 that I last saw the deceased alive on 10/12 1959, and that death occurred at 4 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. W. B. Smith M.D.
ADDRESS (Street, city or town, state): [illegible] Salisbury Md.
DATE SIGNED: 10/15/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/17/59

22c. NAME OF CEMETERY OR CREMATORY: Mechanics Cemetery

22d. LOCATION (City, town, or county) (State): Millsboro - Del.

23. FUNERAL DIRECTOR'S SIGNATURE: Ronald James ADDRESS: Millsboro - Del.

24a. REC'D BY REGISTRAR DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12015

CERTIFICATE OF DEATH

Reg. Dist. No. 11972

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Center St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
d. STREET ADDRESS: Center St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) (Adell)
First: XADELL Middle: LOUISE Last: MARTIN

4. DATE OF DEATH Month: OCT. Day: 9th Year: 1959

5 SEX	6 COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min
Female	White	Widowed	August 22,1882	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work at Home	None	Eden, Maryland	U S A

13. FATHER'S NAME: Solomon Willey
14. MOTHER'S MAIDEN NAME: Maia J.Kelley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO.:
INFORMANT / Address: Mr.Oscar P.Martin(Son) Lakeside Manor Laurel, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral thrombosis	3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	generalized arteriosclerosis	? years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): FRACTURE, Femur, Right - 2 Aug 59

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from August 8, 1959, to Oct. 9, 1959 that I last saw the deceased alive on Oct. 6, 1959, and that death occurred at 10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert T Adkins M.D.
ADDRESS (Street, city or town, state): Fruitland, Maryland
DATE SIGNED: Oct. 10 /1959
PHYSICIAN'S NAME (Type): Dr.Robert T.Adkins

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	Oct.12,1959	Parsons Cemetery	Salisbury,Maryland

23 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY MARYLAND	DATE OCT 13 '59	Arthur S Evans

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11983

CERTIFICATE OF DEATH

11973

Reg. Dist. No.

M

I

1. PLACE OF DEATH
- a. COUNTY: Wicomico — MARYLAND
- b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
- c. LENGTH OF STAY IN 1b: 1 Day
- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
- a. STATE: Maryland
- b. COUNTY: Worcester
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
- d. STREET ADDRESS: 109 Washington St
- e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) — First: Arthur Thomas — Middle: — Last: Mears

4. DATE OF DEATH — Month: October — Day: 14 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 13 – 1892

9. AGE (In years last birthday): 67/8/1 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Parksley, Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Thomas Mears

14. MOTHER'S MAIDEN NAME: Leah Townsend

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-32-0747

INFORMANT — Address: Mrs Mildred C. Mears, Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 3 months

163 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
- DUE TO (b)
- DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1959 to Oct. 13, 1959, that I last saw the deceased alive on Oct. 13, 1959 and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 10/14/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 17/59

22c. NAME OF CEMETERY OR CREMATORY: Bates Methodist Cemetery

22d. LOCATION (City, town, or county): Snow Hill — (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lloyd E. Timmons — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR — DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: C. Rue S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

tem 1[illegible] Film 2[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12016

11974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden(Rural) — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden (Rural)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.#	d. STREET ADDRESS: R.D.# — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: CHARLES Middle: CLEVELAND Last: MEARS	4. DATE OF DEATH — Month: OCTOBER Day: 4th Year: 1959

5. SEX	6. COLOR OR RACE	7.	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	Nov.25,1889	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	House Building	Virginia	U S A

13. FATHER'S NAME: Eugene Mears	14. MOTHER'S MAIDEN NAME: Georginna Sheward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES			Mr.Charles C.MearsJr.(Son)R.D.# Eden, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic cardio-vascular disease	Years
501.0 DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	Cirrhosis of liver	Years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: October 6 1959

EXAMINER'S NAME (Type): Dr.Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct. 7- /59	Parsons Cemetery	Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY MARYLAND	DATE OCT 9 '59	Catherine [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11984

CERTIFICATE OF DEATH

Reg. Dist. No. 11975

082

1. PLACE OF DEATH a. COUNTY ~~Maryland~~ Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showell 23A-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen.Gen. Hospital	d. STREET ADDRESS In Village — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First FRANK	Middle ALFRED	Last MELSON	4. DATE OF DEATH Month OCTOBER Day 25 Year 1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Male	White	Married	July 3,1910	49 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Service Station Manager	(Cities Serv.)	R.D.# Pittsville,Md	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Handy Melson	Laura Alice Workman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
No		Mrs.Wilsie Catherine Melson(Wife) Showell, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, Acute Anterior — INTERVAL BETWEEN ONSET AND DEATH 19 days

422.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Arteriosclerotic Cardiovascular Disease ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial Insufficiency — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10/6, 1959, to 10/25, 1959, that I last saw the deceased alive on 10/24, 1959, and that death occurred at 1:00 A.M., from the causes and on the date stated above.

1

ACTUAL SIGNATURE Rufus S. Gardner, Jr. M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED October 26 /1959

PHYSICIAN'S NAME (Type) Dr.Rufus S.Gardner Jr. — Pine Bluff Rd. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct.27,1959	Line Church Cemetery	R.D.# Pittsville,Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY,MARYLAND	DATE OCT 28 '59	[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11985

CERTIFICATE OF DEATH

Reg. Dist. No. 11976

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marion RFD 19X
d. STREET ADDRESS: RFD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dona Middle: Lee Last: Mister

4. DATE OF DEATH: Month: October Day: 7 Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/27/1874

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Howard

14. MOTHER'S MAIDEN NAME: Mary Tull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

INFORMANT Address: Deer's Head Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — Yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ca. of large bowels with metastasis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 5, 1959, to Oct. 7, 1959, that I last saw the deceased alive on Oct. 7, 1959, and that death occurred at 2:00A.M, from the causes and on the date stated above

ACTUAL SIGNATURE: L. V. Maldve M.D.

ADDRESS (Street, city or town, state): L. V. Maldve, M. D.

DATE SIGNED: 10/7/59

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Deer's Head Hospital; Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-10-59

22c. NAME OF CEMETERY OR CREMATORY: Rehobeth Methodist

22d. LOCATION (City, town, or county) (State): Rehobeth, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kinne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

M

191

VS A1S (4)
TSM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11986

CERTIFICATE OF DEATH

Reg. Dist. No. 11977

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Accomac
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Saxis
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: George Middle: William Last: Mister

4. DATE OF DEATH Month: October Day: 6 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/22/1908

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Tilten Mister

14. MOTHER'S MAIDEN NAME: Andrew D. Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: 223-18-6606

INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Lung
INTERVAL BETWEEN ONSET AND DEATH: 1 yr

163X

DUE TO (b)
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ________ 19____, to ________, 19____, that I last saw the deceased alive on ________, 19____ and that death occurred at 5:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D

ADDRESS (Street, city or town, state): Salisbury Md

DATE SIGNED: 10/6/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/8/59

22c. NAME OF CEMETERY OR CREMATORY: Mister Ceme.

22d. LOCATION (City, town, or county) (State): Saxis VA.

23. FUNERAL DIRECTOR'S SIGNATURE: N. W. Fox Fox Funeral Home

ADDRESS: Temperanceville Virginia

24a. REC'D BY REGISTRAR DATE: OCT 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11987

CERTIFICATE OF DEATH

Reg. Dist. No. 11978

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury; c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen Gen Hospital	d. STREET ADDRESS: East St.; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: THOMAS Middle: Last: MITCHELL

4. DATE OF DEATH Month: OCTOBER Day: 28th Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 21,1884

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter- House

10b. KIND OF BUSINESS OR INDUSTRY: Construction-Employee

11. BIRTHPLACE (State or foreign country): Whitesville,Del.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Elijah J.Mitchell

14. MOTHER'S MAIDEN NAME: Julia Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr.Melvin Brattem(Nephew) Address: 202 Maryland Ave. ~~Salisbury~~ Delmar,Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis with thrombosis

32X

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Lung

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ________ 19____, to ________ 19___, that I last saw the deceased alive on ________ 19______ and that death occurred at ________M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: Oct. 30/1959

PHYSICIAN'S NAME (Type): Dr.David J.Gilmore Medical Center Salisbury,Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.31,1959

22c. NAME OF CEMETERY OR CREMATORY: Line Church Cemetery

22d. LOCATION (City, town, or county) (State): Near Pittsville, Maryland Near Whitesville,Del. (Md.Side)

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY,MARYLAND

24a. REC'D BY REGISTRAR DATE: NOV 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

VS A15 (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11988

CERTIFICATE OF DEATH

Reg. Dist. No. 11979

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	d. STREET ADDRESS: Twin Tree Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: BABY GIRL Middle: Last: Murray	4. DATE OF DEATH Month: October Day: 29 Year: 1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Female	White	Baby	October 29, 1959	0	0	0	1	19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Salisbury, Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James G. Murray	Hilda Jean Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / Address
No	None	Dr. James G. Murray (Father) Twin Tree Rd Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atelectasis

DUE TO (b) Prematurity Birth Wt 1055 gms — [illegible]

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible] to [illegible], 19[illegible] that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C. Kolls M.D. — ADDRESS (Street, city or town, state): Medical Center — DATE SIGNED: [illegible]

PHYSICIAN'S NAME (Type): Dr. Alfred C. Kolls-Medical Cenetr Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct. 30, 1959	Wicomico Memorial Park	Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY, MARYLAND	NOV 2 '59	Arthur S. Kraus

VS A15 (4)
15M 9/58

[illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11989 **CERTIFICATE OF DEATH** 11980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsular General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 211 Marshall St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M C I

3. NAME OF DECEASED (Type or print) First Middle Last Nottingham
4. DATE OF DEATH Month October Day 7 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Baby
8. DATE OF BIRTH 7:10A.M. Oct. 7,1959
9. AGE (In years last birthday) yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min 50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Salisbury(Hospital)Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME William Gilmer
14. MOTHER'S MAIDEN NAME Doris Marie Payne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
17. INFORMANT Address Mr.W.Gilmer Nottingham(Father)211 Marshall St. Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 Hydramnios Congenital Anomalies
DUE TO (b) Hare lip Cleft palate Premature
DUE TO (c) 2 Anencephalus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10-7, 1959 to 10-7, 1959 that I last saw the deceased alive on 10-7, 1959, and that death occurred at 8 A M, from the causes and on the date stated above.
ACTUAL SIGNATURE William S. Womack M.D. ADDRESS (Street, city or town, state) 706 Camden Ave. Salis. Md DATE SIGNED 10/7/59
PHYSICIAN'S NAME (Type) Dr.William S.Womack Salisbury,Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct.8,1959
22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem.Park
22d. LOCATION (City, town, or county) (State) Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE OCT 9 '59
24b. REGISTRAR'S SIGNATURE Claiborne S. Kraus

TO HOSPITAL OR [illegible]TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a[illegible] death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2082374 XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11990 **CERTIFICATE OF DEATH** Reg. Dist. No. 11981

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar, Maryland
d. STREET ADDRESS: R.F.D. #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Hattie Middle: M. Last: Nutter
4. DATE OF DEATH Month: Oct. Day: 4 Year: 19 59

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 11, 1870
9. AGE (In years last birthday): 89 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk
10b. KIND OF BUSINESS OR INDUSTRY: unk
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Marcellus Nutter
14. MOTHER'S MAIDEN NAME: Hester Elzey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unk
16. SOCIAL SECURITY NO: unk
INFORMANT: Hospital Records Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular disease decompensated — Years

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis general — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Sept. 28, 1959, to Oct. 4, 1959, that I last saw the deceased alive on Oct. 4, 1959, and that death occurred at 10:00A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. V. Juerman M.D. ADDRESS (Street, city or town, state): Salisbury, Maryland DATE SIGNED: 10/4/59

PHYSICIAN'S NAME (Type): V. Juerman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 7, 1959
22c. NAME OF CEMETERY OR CREMATORY: Nanticoke Cem.
22d. LOCATION (City, town, or county) (State): Nanticoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. T. Mpsaid ADDRESS: Bivalve, Md.
24a. REC'D BY REGISTRAR DATE: OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1 (4)
1SM 9/58

11982

11991

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: [illegible]
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Quantico
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	d. STREET ADDRESS: — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Theadore Middle: Last: Nutter	4. DATE OF DEATH Month: October Day: 8 Year: 1959
5. SEX: M	6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: October 6 1959
9. AGE (In years last birthday): — yrs	IF UNDER 1 YEAR Months: — Days: 2; IF UNDER 24 HRS Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — n —	10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Salisbury Md.	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Reuben Nutter	14. MOTHER'S MAIDEN NAME: Mariah Church
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —	16. SOCIAL SECURITY NO: —
INFORMANT: Mariah Nutter	Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure

762.5

DUE TO (b) atelectasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Prematurity — 895 gms

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10/6, 1959, to 10/8, 1959, that I last saw the deceased alive on 10/8, 1959, and that death occurred at ____M, from the causes and on the date stated above

ACTUAL SIGNATURE: William C. Morgan M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 10-10-59	22c. NAME OF CEMETERY OR CREMATORY: Quantico Cem	22d. LOCATION (City, town, or county) (State): Quantico Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Booker McWesh	ADDRESS	24a. REC'D BY REGISTRAR DATE: OCT 13 '59	24b. REGISTRAR'S SIGNATURE: Arthur [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2 5 2272 X

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11983

11992

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Wic.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Md

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General

d. STREET ADDRESS 673 - Delaware St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Samuel Middle Last Parker

4. DATE OF DEATH Month October Day 1 Year 1959

5. SEX Male

6. COLOR OR RACE Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 30 1902

9. AGE (In years last birthday) 57 yrs

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor

10b KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joe Parker

14. MOTHER'S MAIDEN NAME Ella Garrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 272-10-4840

INFORMANT Maggie Parker Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident

DUE TO

(b) Hypertension

DUE TO

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH 4 days; [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from 1 Sept 1959 to 1 Oct 1959 that I last saw the deceased alive on 1 Oct 1959, and that death occurred at 8:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE E Purnell M.D. ADDRESS (Street, city or town, state) 652 W Main DATE SIGNED 3 Oct 59

PHYSICIAN'S NAME (Type) E. A. Purnell M.D. Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct 5-1959

22c. NAME OF CEMETERY OR CREMATORY Gypsy Acres Cem

22d. LOCATION (City, town or county) Salisbury (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Booker McCleaf ADDRESS

24a. REC'D BY REGISTRAR DATE OCT 9 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG250 10-26-59 et

11993

CERTIFICATE OF DEATH

Reg. Dist. No. 11984

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b: 26yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 307 E. William St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

d. STREET ADDRESS: 307 E. William St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: MARY Middle: SCARBOROUGH Last: PETERS

4. DATE OF DEATH Month: October Day: ~~20~~ 19 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 1,1885 ~~October 20,1885~~

9. AGE (in years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James S. Scarborough

14. MOTHER'S MAIDEN NAME: Annie Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO. *****

16. SOCIAL SECURITY NO.

17. INFORMANT: Frank H. Peters Address: Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon with local extension and

153.8

DUE TO (b) metastases.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/25, 1955, to 10/19, 1959, that I last saw the deceased alive on 10/16, 1959, and that death occurred at 5:55 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner Jr. M.D.

ADDRESS (Street, city or town, state) DATE SIGNED: 10/20/59

PHYSICIAN'S NAME (Type): Rufus S. Gardner, Jr. M.D. Pine Bluff Road, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/21/1959

22c. NAME OF CEMETERY OR CREMATORY: Wahtcoat Cemetery

22d. LOCATION (City, town, or county) (State): Snow Hill Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co. ADDRESS: Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 22 59

24b. REGISTRAR'S SIGNATURE: Arthur S. Russ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ■ should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11994

Reg. Dist. No. 11985

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Florida b. COUNTY:
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury / c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Miami
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	d. STREET ADDRESS: 419 N. Eighth St. / e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Eunice Middle: Last: Pugh	4. DATE OF DEATH Month Day Year: 10-14-59 19

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	C	Married		33 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md	U.S.A.

13. FATHER'S NAME: Clin Talley	14. MOTHER'S MAIDEN NAME: Jeanette Talley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / Address
		Jeanette Talley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in accident Route # 13.

20c. TIME OF INJURY Hour a.m./p.m. — Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
4 P.M. 10-14-59.	Not while at work	Route # 13	Pocomoke Worcester Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D. 10-15-59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
[illegible]	10-19-59	Mt Calvary C[illegible]	[illegible]

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
[illegible] 1000 [illegible] Ave	DATE OCT 19 '59	Arthur S Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is n[redacted]ory, please execute the certi[redacted] writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and [redacted] the funeral direc[redacted]age 4 should be forwarded to [redacted]hief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11995

Reg. Dist. No. 11986

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
d. STREET ADDRESS: 312 Charles St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Purcell

4. DATE OF DEATH: Month: 10 — Day: 27 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-24-82

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland (Salisbury)

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Henry Marvel

14. MOTHER'S MAIDEN NAME: Ardelia Elizabeth Hearne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.: --

INFORMANT — Address: Deer's Head Hospital Records
Mr. J. Fulton Purcell (Son) Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Hypostatic pneumonia	36 hrs.
DUE TO (b)	Hypertensive arteriosclerotic cardiovascular dis.	Yrs.
DUE TO (c)		

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I **certify** that I attended the deceased from 10-21, 1959, to 10-27, 1959, that I last saw the deceased alive on 10-27, 1959, and that death occurred at 5:28 p.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital, Salisbury, Maryland — DATE SIGNED: 10-28-59

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 30, 1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND
24a. REC'D BY REGISTRAR — DATE NOV 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11996

CERTIFICATE OF DEATH

Reg. Dist. No. 11987

1. PLACE OF DEATH
   a. COUNTY: Wicomico MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 228 Newton St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: ROBERT Middle: MARTIN Last: RICHMOND

4. DATE OF DEATH — Month: Oct. Day: 9th Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 10, 1898

9. AGE (In years last birthday): 60 yrs — IF UNDER 1 YEAR: Months 10 Days 29 — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) / 10b. KIND OF BUSINESS OR INDUSTRY: Salesman-Self Employeed- Safe Co.

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Richmond

14. MOTHER'S MAIDEN NAME: Margaret M.Gamble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): YES-W.W.#1(British Army)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs.Mary K.Richmond(Wife) Address: 228 Newton St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

420.1

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10-8, 1959, to 10-9, 1959, that I last saw the deceased alive on 10-9, 1959, and that death occurred at 12:30A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilber R. Ellis Jr. M.D.

ADDRESS (Street, city or town, state):

DATE SIGNED: Oct. 10 /1959

PHYSICIAN'S NAME (Type): Dr.Wilber R.Ellis Jr. — Medical Center - Salisbury,Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.11,1959

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11997 CERTIFICATE OF DEATH Reg. Dist. No. 11988

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY Somerset
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury — c LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West over, Md. 19X-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 08' Peninsula General Hospital	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First ELMIRA Middle SPENCER Last SMITH — 4. DATE OF DEATH Month October Day 13 Year 1959

5. SEX Female — 6. COLOR OR RACE Col. — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8 DATE OF BIRTH Oct. 23 1907 — 9 AGE (in years last birthday) 51 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b KIND OF BUSINESS OR INDUSTRY Housework — 11. BIRTHPLACE (State or foreign country) Maryland — 12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Aichey — 14. MOTHER'S MAIDEN NAME Alice ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO — INFORMANT John Smith Address 2142 N. Lha. ST. Phila, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrovascular Accident — 2 das

443X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Hypertensive Cardiovascular Disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/12, 1959, to 10/13, 1959, that I last saw the deceased alive on 10/13, 1959, and that death occurred at 8 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Rufus S. Gardner Jr M.D — ADDRESS (Street, city or town, state) PINEBLUFF Rd. SALISBURY, Md. — DATE SIGNED 10/13/59

PHYSICIAN'S NAME (Type) RUFUS S. GARDNER JR

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF 10-16-59 — 22c. NAME OF CEMETERY OR CREMATORY Lindley Chapel — 22d LOCATION (City, town, or county) Pocomoke, Md. (State)

23 FUNERAL DIRECTOR'S SIGNATURE Elijah Whorton — ADDRESS New Church, Va. — 24a REC'D BY REGISTRAR DATE OCT 23 '59 — 24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

VS A1S (4)
15M 9/58

[illegible] 5

1

TO HOSPITAL O[illegible]TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a[illegible]death. Page 4 may be retained the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11998

CERTIFICATE OF DEATH

11989
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 120 Walston Ave

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 120 Walston Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ROSA Middle ALICE Last SMITH
4. DATE OF DEATH Month OCTOBER Day 13th Year 19 59

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH March 31,1872
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months 6 Days 12
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Wicomico County, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME William M.Gordy
14. MOTHER'S MAIDEN NAME Hester Oliphant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Mr.Louis B.Smith(Son) Address 120 Walston Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cerebral hemorrhage
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH 1 Mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to 10/13, 1959, that I last saw the deceased alive on 10/13, 1959, and that death occurred at 3:45P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Earl Beardsley M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED October/6 /59
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury,Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct.16,1959
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery
22d. LOCATION (City, town, or county) (State) Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE OCT 19 '59
24b. REGISTRAR'S SIGNATURE William S. Kinsch

VS A15 (4)
15M 9/58

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11999 11996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 604 Rose St	d. STREET ADDRESS: 604 Rose St — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First: Virginia Middle: Last: Smith	4. DATE OF DEATH Month: 10 Day: 5 Year: 1959
5. SEX: Fm — 6. COLOR OR RACE: N — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 3-15-1927 — 9. AGE (In years last birthday): 32 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor — 10b. KIND OF BUSINESS OR INDUSTRY: Chicken	11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charlie Bacon	14. MOTHER'S MAIDEN NAME: Evelyn White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO: 28-16-7890	17. INFORMANT: Marion Bacon — Address: Georgetown, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

982X

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck in forehead c axe

20c. TIME OF INJURY Hour 9 p.m. Month, Day, Year 10-5-1959 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☒ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home — 20f. (City or town) Salisbury (County) Wicomico (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-13-59

EXAMINER'S NAME (Type): EARL L. ROYER, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	10-10-59	Green Acre Mem Park	Salisbury	Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Thornton B. Jolley	Salisbury Md	DATE OCT 19 '59	[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BS A15ME
5M 2/57

I X

11991

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12000

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
   d. STREET ADDRESS: 1 Prince St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ASBURY — Middle: QUINTON — Last: TRUITT

4. DATE OF DEATH: Month: October — Day: 29 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan.28, 1892

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months 9, Days 1 — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer --

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Worcester Co.Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Samuel H.Truitt

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Driscoll

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

INFORMANT: Mrs.Bernice Truitt(Wife) — Address: Prince St Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — Minutes

420.1

DUE TO (b) Coronary Thrombosis — Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Atherosclerotic cardiovascular disease — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/12/ 1958 to 10/29/ 1959 that I last saw the deceased alive on 1/9/ 1959, and that death occurred at 12:20A.M. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Maryland Ave. Salisbury, Maryland

DATE SIGNED: Oct. 30/59

PHYSICIAN'S NAME (Type): Dr.O.J.Burton

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov.1,1959

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAN D

24a. REC'D BY REGISTRAR DATE: NOV 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12001

CERTIFICATE OF DEATH

Reg. Dist. No. 11992

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg Rural
d. STREET ADDRESS Near Reliance
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First George Middle Raymond Last Truitt, Jr.
4. DATE OF DEATH Month October Day 27 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Mar. 10, 1891
9. AGE (In years last birthday) 68 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Raymond Truitt
14. MOTHER'S MAIDEN NAME Ella Helens
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. Not any
INFORMANT Address Mrs. Audrey B. Truitt, Federalsburg, Md. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
420.0
DUE TO (b) arterio sclerotic heart disease — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c) Intestinal obstruction due to carcinoma rectum

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/24, 1959, to 10/27, 1959, that I last saw the deceased alive on 10/27, 1959, and that death occurred at 7:05 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE H. A. Briele M.D. ADDRESS (Street, city or town, state) Medical Center Salisbury, Md. DATE SIGNED 10-28-59
PHYSICIAN'S NAME (Type) H. A. Briele

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-29-1959
22c. NAME OF CEMETERY ~~OR CREMATORY~~ Hill Crest
22d. LOCATION (City, town, or county) (State) Federalsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. K. W. Boyer, Harrington, Del.
24a. REC'D BY REGISTRAR DATE NOV 4 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL [redacted] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11993

12017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 74 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 412 Pine Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: 412 Pine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: William — Middle: C. — Last: Truitt

4. DATE OF DEATH — Month: Oct. — Day: 26, — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1885
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Conductor
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Silas James Truitt
14. MOTHER'S MAIDEN NAME: Sallie Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): --------
16. SOCIAL SECURITY NO.: 711-07-1575
17. INFORMANT — Address: Esther Truitt, Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
442
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) advanced arteriosclerosis
DUE TO (c) cardio-renal disease

INTERVAL BETWEEN ONSET AND DEATH: 6 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1959, to 10-26, 1959 that I last saw the deceased alive on 10-25, 1959, and that death occurred at 1 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. [illegible] M.D.
ADDRESS (Street, city or town, state): Laurel, Del
DATE SIGNED: 10/27/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-29-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery
22d. LOCATION (City, town, or county) (State): Delmar, Del.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. S. Marvel Co. [illegible]
24a. REC'D BY REGISTRAR DATE: OCT 29 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12002

Reg. Dist. No. 11994

1. PLACE OF DEATH
a. COUNTY: Wicomico, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES [x] NO [ ]

3. NAME OF DECEASED (Type or print): First: Henry Middle: Last: Turner

4. DATE OF DEATH: Month 10 Day 21 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [x] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct.8, 1875
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Turner
14. MOTHER'S MAIDEN NAME: Mary Downey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): x (If yes, give war or dates of service): x
16. SOCIAL SECURITY NO.: x
17. INFORMANT: Mrs. Emma J. Turner Address: Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: hours
490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture ribs + Fracture of left humerus

19. WAS AUTOPSY PERFORMED? YES [x] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [x] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Walked in front of auto
20c. TIME OF INJURY: Hour 11:45 a. m. Month, Day, Year: 10 17 1959
20d. INJURY OCCURRED: While at work [ ] Not while at work [x]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Bishop (County) Worcester (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [x], Inspection [x], Inquiry [ ], and find that death resulted from: Natural causes [ ], Accident [x], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [x]
DATE SIGNED: 10-22-59
EXAMINER'S NAME (Type): Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/24/59
22c. NAME OF CEMETERY OR CREMATORY: I. O. O. F.
22d. LOCATION (City, town, or county) (State): Bishopville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Selbyville Del
24a. REC'D BY REGISTRAR DATE: OCT 26 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

VS. A15ME(5)
5M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12018

CERTIFICATE OF DEATH

11995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Md. b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [redacted]
c. LENGTH OF STAY IN 1b: 4 yrs
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D.
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: P. Middle: Frank Last: Tyre
4. DATE OF DEATH Month: 10 Day: 16 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/19/1894
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benjamin Tyre
14. MOTHER'S MAIDEN NAME: Amelia Foskey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: [illegible]-14-4024
17. INFORMANT / Address: Jennie Tyre - Parsonsburg - Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — unknown

002X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Chronic Myocardial Decompensation — unknown

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10-2, 1959 to 10-16, 1959, that I last saw the deceased alive on 10-14, 1959, and that death occurred at 6 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V. A. Hudson M.D.
ADDRESS (Street, city or town, state): Millsboro Del
DATE SIGNED: 10-17-59

PHYSICIAN'S NAME (Type): V. A. HUDSON M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10/19/59
22c NAME OF CEMETERY OR CREMATORY: Line Cemetery
22d LOCATION (City, town, or county) (State): Pittsville Md. R.F.D.

23 FUNERAL DIRECTOR'S SIGNATURE: Ronald James
ADDRESS: Millsboro, Del
24a. REC'D BY REGISTRAR DATE: OCT 20 59
24b REGISTRAR'S SIGNATURE: C. Allen S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

VS A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11996
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: 12003 Wicomico MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE: Maryland b. COUNTY: Somerset

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne

d. STREET ADDRESS: Jarmon Farm Box 57

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Lorraine Middle: Vinson Last:

4. DATE OF DEATH Month Day Year: 10-3-59 19

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1920

9. AGE (In years last birthday): 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Fla

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Oscar Vinson Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous sub-arachnoid hemorrhage- INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-8-59

[redacted]
NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-8-59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

22d. LOCATION (City, town, or county) (State): Fruitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker M. West ADDRESS

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur Atkins

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12019

CERTIFICATE OF DEATH

11997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke	c. LENGTH OF STAY IN 1b: Lifetime
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —	d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	

3. NAME OF DECEASED (Type or print) First / Middle / Last: ROBERT J. WALLACE	4. DATE OF DEATH Month / Day / Year: Oct. 1 1959
5. SEX: Male	6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 3-6-1880
9. AGE (In years last birthday): 79 yrs.	IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman	10b. KIND OF BUSINESS OR INDUSTRY: Oysterman
11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Robert Wallace	14. MOTHER'S MAIDEN NAME: Louise Hardy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No —	16. SOCIAL SECURITY NO.: 219-34-3337A
17. INFORMANT Address: Hillary Wallace, Nanticoke, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Occlusion	1 day
420.0 DUE TO (b)	Arteriosclerotic Heart Disease.	10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Inanition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 July, 1959, to 1 Oct, 1959, that I last saw the deceased alive on 1 Oct, 1959, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H Saunders M.D. ADDRESS (Street, city or town, state): Nanticoke, Md DATE SIGNED: 2 Oct. 59

PHYSICIAN'S NAME (Type): Richard H. Saunders Nanticoke, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 10/4/59
22c. NAME OF CEMETERY OR CREMATORY: Nanticoke Cem.	22d. LOCATION (City, town, or county) (State): Nanticoke, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. D. Messick, Bivalve, Md.	24a. REC'D BY REGISTRAR DATE: OCT 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12004

CERTIFICATE OF DEATH

Reg. Dist. No. 11998

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 428 E.Church St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: WILLIAM Middle: WHITELEY Last: WALLER

4. DATE OF DEATH Month: OCTOBER Day: 17th Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 14,1892

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR Months: 4 Days: 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Painter

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (State or foreign country): Delmar,Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William J. Waller

14. MOTHER'S MAIDEN NAME: Virgie Emma Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk

16. SOCIAL SECURITY NO.

17. INFORMANT (Address): Mrs.Catherine L.Waller(Wife)428 E.Church St. Salisbury,Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident

331X

DUE TO (b) Arterio sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid arthritis - Chronic myocarditis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from ________ 1950, to 10-17 1959 that I last saw the deceased alive on 10-17 1959, and that death occurred at 2:20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip A Insley M.D.

ADDRESS (Street, city or town, state) DATE SIGNED: Oct. 19 1959

PHYSICIAN'S NAME (Type): Dr.Philip Insley — Main St. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.19,1959

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY,MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Knack

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12005 **CERTIFICATE OF DEATH** Reg. Dist. No. 11999

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: M ryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury; c. LENGTH OF STAY IN 1b: 5 Hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	d. STREET ADDRESS: Riverside Dr.; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: PERRY Middle: ALEXANDER Last: WHITE
4. DATE OF DEATH Month: 10 Day: 16 Year: 1959

5. SEX: Male | 6. COLOR OR RACE: White | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH: Oct,30,1899 | 9. AGE (in years last birthday): 59 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): J.W.White Candy Wholesale
10b. KIND OF BUSINESS OR INDUSTRY: Retired owner
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JohWW. White
14. MOTHER'S MAIDEN NAME: Angie Webster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Beatrice White, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
DUE TO (b) ASCVD — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-13, 1956 to 10-16, 1959 that I last saw the deceased alive on 10-16, 1959, and that death occurred at 3:00PM M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl L. Royer M.D.
ADDRESS (Street, city or town, state): Salisbury, MAryland
DATE SIGNED: 10-16-59

PHYSICIAN'S NAME (Type): Dr. Earl L. Royer Camden Ave., Salisbury, MAryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-18-59
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial PArk
22d. LOCATION (City, town, or county) (State): Salisbury, M ryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Hill & Johnson Co. Salisbury, MAryland
24a. REC'D BY REGISTRAR DATE: OCT 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4) 15M 9/55

Norman T Baker

X-1 X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12020

CERTIFICATE OF DEATH

Reg. Dist. No. 12000

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
d. STREET ADDRESS: Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Bernard — Middle: Lewis — Last: Wilkinson

4. DATE OF DEATH Month: OCTOBER ~~Aug.~~ Day: 11, Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14, 1895
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist
10b. KIND OF BUSINESS OR INDUSTRY: Drugs
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Wilkinson
14. MOTHER'S MAIDEN NAME: Lillie Seabrease

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W W # 1
16. SOCIAL SECURITY NO: 218-05-8028
17. INFORMANT — Address: Mary Bailey Wilkinson, Sharptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Coronary Insufficiency — 10 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ________ 1950 to Oct 11 1959, that I last saw the deceased alive on Oct 11 1959, and that death occurred at 6 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H S Kuhlman M.D. — ADDRESS (Street, city or town, state): Sharptown Md — DATE SIGNED: 10/13/59

PHYSICIAN'S NAME (Type): H. S. Kuhlman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-14-59
22c. NAME OF CEMETERY OR CREMATORY: Taylor
22d. LOCATION (City, town, or county) (State): Sharptown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles W. Mann — Sharptown Md
24a. REC'D BY REGISTRAR DATE: OCT 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12006 Item 7 Fil.G2,0 10-2?-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 12001

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marion Station
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) — First: Seuel (SEWELL) Middle: — Last: Williams

4. DATE OF DEATH — Month: October Day: 21 Year: 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Apr. 15, 1909

9. AGE (In years last birthday): 50 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: SEAFOOD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE WILLIAMS

14. MOTHER'S MAIDEN NAME: ELIZABETH TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: DAISY JOHNSON, CRISFIELD, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Renal Failure with Uremia

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Kimmelstiel-Wilson Syndrome
DUE TO (c) Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 19, 1959, to October 21, 1959, that I last saw the deceased alive on October 20, 1959, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D. — ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Md. — DATE SIGNED: 10/21/59

PHYSICIAN'S NAME (Type): THOMAS C. HILL JR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: OCT 24, 1959

22c. NAME OF CEMETERY OR CREMATORY: EBENEZER CEM.

22d. LOCATION (City, town, or county) (State): MARION, MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: BRADSHAW & SONS CRISFIELD, MD

24a. REC'D BY REGISTRAR DATE OCT 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

12007

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: Birth Cert. et

CERTIFICATE OF DEATH

Reg. Dist. No. 13147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

C

082

I

Field	Entry
1. PLACE OF DEATH a. COUNTY (MARYLAND)	Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Salisbury
c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Peninsula General Hospital
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	Maryland
b. COUNTY	Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Princess Anne 14
d. STREET ADDRESS	Rt. # 3, Box # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐	
3. NAME OF DECEASED (Type or print) First / Middle / Last	Baby / Boy / Wolfkill
4. DATE OF DEATH Month / Day / Year	October 30 1959
5. SEX	Male
6. COLOR OR RACE	White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
8. DATE OF BIRTH	October 29, 1959
9. AGE (In years last birthday)	1day
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Edgar Wolfkill
14. MOTHER'S MAIDEN NAME	Virginia Adkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
INFORMANT / Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxia

762.5

DUE TO (b) Atelectasis

DUE TO (c) Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/29 19 59, to 10/30, 19 59, that I last saw the deceased alive on ______, 19____, and that death occurred at 2 40 P M, from the causes and on the date stated above

ACTUAL SIGNATURE [signature] M.D. ADDRESS (Street, city or town, state) Ned Center, Md. DATE SIGNED 11/1/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/30/59	Beechwood Memorial	Princess Anne Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
James Henson	Princess Anne	NOV 1 8 '59	Arthur S. Kraus

VS A15 (4)
15M 9/58

1

2012201XVS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12008

CERTIFICATE OF DEATH

Reg. Dist. No. 12002

1. PLACE OF DEATH
- a. COUNTY: Wicomico — MARYLAND
- b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
- c. LENGTH OF STAY IN 1b:
- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
- a. STATE: Maryland
- b. COUNTY: Wicomico
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Willards
- d. STREET ADDRESS: /
- e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Walsie Middle: Mae Last: Wootten

4. DATE OF DEATH Month: October Day: 12 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 4, 1904

9. AGE (In years last birthday): 55 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Whaleysville Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Uriah Hudson

14. MOTHER'S MAIDEN NAME: Sarah Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT Address: Mr. Harry L. Wootten, Willards Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Metastatic Fibrosarcoma.	
197.3 — DUE TO (b)	Fibrosarcoma – Thigh – Left.	6 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ——

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ——

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 9-12, 1959, to 10-12, 1959, that I last saw the deceased alive on 10-12, 1959, and that death occurred at 8:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. Gray Reus M.D. ADDRESS (Street, city or town, state): Medical Center, Salisbury, Md DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/15/59

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Evergreen

22d. LOCATION (City, town, or county): Berlin (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md.

24a. REC'D BY REGISTRAR DATE: OCT 15 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

12003

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12009

CERTIFICATE OF DEATH

Reg. Dist. No. 05 X-2

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 159 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg
d. STREET ADDRESS: 220 S. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First: Laura Middle: Virginia Last: Wothers

4. DATE OF DEATH: Month: October Day: 20 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/12/1869

9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland (Caroline Co.)

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ezekiel Jarrell

14. MOTHER'S MAIDEN NAME: Mary Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: None

INFORMANT / Address: Deer's Head Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

	Cause	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic cardiovascular disease	Years
DUE TO (b)	Arteriosclerosis, general	Years
DUE TO (c)		

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 14, 1959, to October 20, 1959, that I last saw the deceased alive on October 20, 1959, and that death occurred at 1:15AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve, M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital, Salisbury, Maryland
DATE SIGNED: 10/20/59

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.23,1959

22c. NAME OF CEMETERY OR CREMATORY: ~~Federalsburg Cemetery~~ Hill Crest Cemetery

22d. LOCATION (City, town, or county) (State): Federalsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J.J.Frempton and Son, Federalsburg, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 22 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

12069

X 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12010

CERTIFICATE OF DEATH

12004

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 314 Delaware Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1 314 Delaware Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Norman Middle: R. Last: Wright

4. DATE OF DEATH Month: October Day: 4 Year: 1959

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Oct. 4, 1892
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilmore Wright
14. MOTHER'S MAIDEN NAME: Merniva King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Sophia Robinson 102 Second St Salis. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

420.1

DUE TO (b) Arteriosclerosis — Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Apr, 1958 to 4 Oct, 1959, that I last saw the deceased alive on 4 Oct, 1959, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Purnell M.D.
ADDRESS (Street, city or town, state): 652 W. Main St Salisbury Md
DATE SIGNED: 9 Oct 59
PHYSICIAN'S NAME (Type): E. A. PURNELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/9/1959
22c. NAME OF CEMETERY OR CREMATORY: Green Acres
22d. LOCATION (City, town, or county) (State): Salisbury Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart ADDRESS: Salisbury Md

24a. REC'D BY REGISTRAR DATE OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kinas

VS A15 (4)
15M 10/57